

McLaren Print System Order

Order No: 44404 Reprint Previous Order No: 5567
Order Date: 2019-04-11
User: tiffany mclaughlan
Phone: 586-286-4880

Ship Location: McLaren Womens Health Clinton Attn: Tiffany
37400 Garfield
Clinton Township, Michigan 48036

Forms

Quantity: 500
Paragon Dept No: 52100
Dept Name: McLaren Womens Health Clinton Township
Company Number: 810

Order Total Price: 0.00

Item Number: MM-140
Item Description: OB/GYN Questionnaire
Revision Date: 10/2018
Print: 2 sided black and white
Paper: 20# White Text
Size: 8.5 x 11
Fold:
Finish:
Drill: None
Misc Info:

McLAREN MEDICAL GROUP
OB/GYN QUESTIONNAIRE

DATE: _____ LEGAL NAME: _____ MAIDEN NAME: _____

HISTORY

Pregnancies: <input type="checkbox"/> None <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12 <input type="checkbox"/> 13 <input type="checkbox"/> 14 <input type="checkbox"/> 15 <input type="checkbox"/> 16 <input type="checkbox"/> 17 <input type="checkbox"/> 18 <input type="checkbox"/> 19 <input type="checkbox"/> 20 <input type="checkbox"/> 21 <input type="checkbox"/> 22 <input type="checkbox"/> 23 <input type="checkbox"/> 24 <input type="checkbox"/> 25 <input type="checkbox"/> 26 <input type="checkbox"/> 27 <input type="checkbox"/> 28 <input type="checkbox"/> 29 <input type="checkbox"/> 30 <input type="checkbox"/> 31 <input type="checkbox"/> 32 <input type="checkbox"/> 33 <input type="checkbox"/> 34 <input 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PERIODS: Age started: _____ Age stopped: _____
Flow is: heavy medium light How many days in a cycle: _____ First day of last menstrual period: _____
Any recent changes in periods: No Yes Explain: _____

BIRTH CONTROL: No Yes Method: _____

Last Mammogram: _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Last Pap: _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Any history of Abnormal Pap: <input type="checkbox"/> No <input type="checkbox"/> Yes
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GENERAL:
 Fever Chills Sweats Fatigue
 Weight loss Hoarseness Swelling
 Anorexia Loss of appetite
 Weight gain Constipation

EYES:
 Blurred vision Double vision
 Itching Itchy eyes

EARS, NOSE, THROAT, MOUTH:
 Sore throat
 Hoarseness
 Difficulty swallowing
 Frequent nose bleeds
 Dry mouth

RESPIRATORY:
 Shortness of breath
 Cough
 Wheezing
 Chest pain
 Difficulty breathing
 Sore throat

CARDIOVASCULAR:
 High blood pressure
 Chest pain
 Dizziness
 Fainting
 Swelling in legs

GASTROINTESTINAL:
 Stomach problems
 Constipation
 Diarrhea
 Nausea
 Vomiting
 Blood in stool
 Black or tarry stool
 Unintentional weight loss
 Difficulty swallowing

NEUROLOGICAL:
 Headaches
 Dizziness
 Lightheadedness
 Tremors
 Seizures
 Memory loss
 Depression
 Anxiety
 Sleep problems
 Tingling or numbness
 Weakness

GENITOURINARY:
 Urinary tract problems
 Urinary frequency
 Urinary urgency
 Urinary incontinence
 Painful urination
 Blood in urine
 Painful intercourse
 Abnormal vaginal discharge
 Vaginal dryness
 Painful intercourse

SKIN AND BREASTS:
 Skin rashes
 Dry skin
 Itching
 Hair loss
 Changes in breast shape
 Changes in breast color
 Changes in breast texture
 Changes in breast size
 Changes in breast shape

ENDOCRINE:
 Thyroid problems
 Diabetes
 Adrenal problems
 Pituitary problems

HEMATOLOGICAL/IMMUNE:
 Anemia
 Leukemia
 Lymphoma
 Multiple myeloma
 Hematoma
 Bruising
 Bleeding

ALLERGIC/IMMUNOLOGIC:
 Allergies
 Asthma
 Eczema
 Hay fever

REPRODUCTIVE HEALTH:
 Menstrual problems
 Painful intercourse
 Difficulty getting pregnant
 Miscarriages
 Stillbirths
 Infertility

OFFICE USE ONLY:
 Special Learning Needs: No Yes, specify: _____
 Language Preference for Healthcare: English Other specify: _____
 Provider's Signature: _____ Date/Time: _____

Print Name: _____
 Date of Birth: _____

OB/GYN QUESTIONNAIRE
 04/10/2018